



**MINUTES FROM THE MEETING OF THE STATE EMPLOYEE BENEFITS COMMITTEE  
FEBRUARY 28, 2022**

The State Employee Benefits Committee (the “Committee”) met at 2:00 p.m. on February 28, 2022. The meeting was held at 97 Commerce Way, Suite 201, in Dover; however, in the interests of protecting the citizens of this State from the public health threat caused by COVID-19, this meeting was presented via WebEx, and participants were encouraged to attend virtually.

Committee Members Represented or in Attendance:

Director Cerron Cade, Office of Management & Budget (“OMB”), SEBC Co-Chair  
Secretary Claire DeMatteis, Department of Human Resources (“DHR”), Co-Chair  
The Honorable Colleen Davis, State Treasurer, Office of the State Treasurer (“OST”)  
The Honorable Trinidad Navarro, Insurance Commissioner, Department of Insurance (“DOI”)  
The Honorable Chief Justice Collins Seitz, Delaware Supreme Court  
Controller General Ruth Ann Jones, Office of the Controller General (“OCG”)  
Secretary Molly Magarik, Department of Health & Social Services (“DHSS”)  
Mr. Jeff Taschner, Executive Director, Delaware State Education Association (“DSEA”)  
Mr. Keith Warren, Chief of Staff, Office of the Lieutenant Governor (Designee OBO The Honorable Bethany Hall-Long, Lieutenant Governor)  
Ms. Ashley Tucker, Deputy State Court Administrator, Admin Office of the Courts (Designee OBO The Honorable Chief Justice Collins Seitz, Delaware Supreme Court)

Others in Attendance

Director Faith Rentz, Statewide Benefits Office (“SBO”), DHR	Dr. Jessilene Corbett, Deputy Secretary, DHR
Deputy Director Leighann Hinkle, SBO, DHR	Mr. Steven Costantino, Dir. Healthcare Reform, DHSS
Ms. Nina Figueroa, SBO, DHR	Ms. Sue Dahms, Highmark Delaware
Deputy Attorney General Adria Martinelli, Dept. of Justice (“DOJ”), SEBC Legal Counsel	Ms. Cherie Dodge Biron, Deputy Principal Asst., DHR
Mr. Chris Giovannello, Willis Towers Watson (“WTW”)	Ms. Sara Dunlevy, CVS Health
Ms. Jaclyn Iglesias, WTW	Mr. John Ficaró, Aetna
Ms. Rebecca Warnken, WTW	Ms. Darcell Griffith, University of Delaware
Ms. Gabby Costagliola, WTW	Ms. Rishika Gupta, CVS Health
Ms. Joanna Adams, Pension Administrator, Office of Pensions (“OPen”)	Ms. Jeanette Hammon, Sr. Fiscal Policy Analyst, OMB
Ms. Judy Anderson, DSEA	Ms. Sandy Hart, IBM Watson Health
Ms. Wendy Beck, Highmark Delaware	Mr. John Hintz, Christiana School District, retiree
Mr. Ken Bronke, Highmark Delaware	Ms. Charlene Hrivnak, CVS Health
Ms. Christina Bryan, Delaware Healthcare Association	Ms. Katherine Impellizzeri, Aetna
Mr. Randall Bryniarski, CVS Health	Dr. Mark Jacobson, Highmark Delaware
Ms. Rebecca Byrd, ByrdGomes	Mr. Kollin Jensen, Teladoc Health
Ms. Michelle Carpenter, PHRST	Ms. Heather Johnson, Controller, DHR
Ms. Julie Caynor, Aetna	Mr. Jamie Johnstone, Deputy Principal Assistant, Dept. of Finance (“DOF”)
Ms. Marian Coker, Information Resource Specialist, Department of State	Mr. Adam Knox, Highmark Delaware
	Ms. Lisa Mantegna, Highmark Delaware
	Mr. Walt Mateja, IBM Watson Health
	Ms. Gisela McKenzie, University of Delaware

**STATE OF DELAWARE STATEWIDE BENEFITS OFFICE**

Mr. Sean McNeeley, Director of Bond Finance, DOF  
 Mr. Nick Moriello, Highmark Delaware  
 Ms. Kathy Nedelka, HRIS Specialist, PHRST, OMB  
 Ms. Brooke Nedza, Aetna  
 Ms. Evelyn Nestlerode, Deputy State Court  
 Administrator, CFO, AOC  
 Mr. Michael North, Aetna  
 Ms. Megan Richards, Aetna  
 Ms. Paula Roy, Roy Associates  
 Ms. Elizabeth Sampo, Aetna

Mr. Bill Sarniak, Highmark Delaware  
 Ms. Carrie Schiavo, Delta Dental  
 Ms. Christine Schiltz, Parkowski Guerke & Swayze, P.A.  
 Mr. Robert Scoglietti, Deputy Controller General, OCG  
 Mr. Mike Shipley, Highmark Delaware  
 Mr. Charles Simons, Highmark Delaware  
 Ms. Jacqueline Faulcon, READAAMs. Martha Sturtevant,  
 Exec. Sec., SBO, DHR  
 Ms. Carole Mick, SBO, DHR – Recorder

**CALLED TO ORDER – DIRECTOR CADE, CO-CHAIR**

Director Cade called the meeting to order at 2:00 p.m.

**APPROVAL OF MINUTES – DIRECTOR FAITH RENTZ, DHR, SBO**

A MOTION was made by Secretary Magarik and seconded by Controller General Jones to approve the minutes from the January 24, 2022, meeting of the State Employee Benefits Committee.

MOTION ADOPTED UNANIMOUSLY

**DIRECTOR’S REPORT – DIRECTOR FAITH RENTZ, DHR, SBO**

Medicare Part D – EGWP Transition Updates

Through 1/31/22, 70% (19,612) of the State’s average eligible Medicare members (27,886) utilized the pharmacy benefit through CVS/SilverScript. Over 66,000 claims were processed at a total amount paid of \$13.7M, almost \$13M of this was paid by the State’s plan (94%) and 6% paid by Medicare retirees. Call volume increased somewhat in early February; however, this has leveled off in the last 2 weeks. There were common themes in calls and customer service tickets being tracked by the SBO and Pension Office. The first common theme is Medicare Part B vs Part D Coordination for Immunosuppressants. Some members were denied coverage when transitioning to SilverScript, due to CMS records not being updated correctly. The SBO has been providing exception overrides while this information gets updated between CMS and SilverScript. Another issue concerning members is a copay increase due to members prescriptions not being on the drug formulary. Members can request SilverScript to cover a drug due to medical necessity. If a drug does become covered, it will be covered at the Tier Three Copay for Non-Formulary Drugs. SilverScript does offer preferred drug alternatives on the formulary. Formulary changes occur several times throughout the year due to re-contracting that the Pharmacy Benefits Manager (PBM) goes through with drug manufacturers, so members will see disruptions regardless of the change in PBM. Lastly, members are facing challenges with obtaining prior authorizations for prescriptions with the transition to SilverScript. Affected Medicare retirees were notified in early December about the transition to SilverScript and informed that they would need a new prior authorization and offered a 31-day transition fill for their first fill after January 1<sup>st</sup>, 2022. Medicare Part D members do have five levels of appeals to request consideration for prescription medication.

**2021 HEALTH THIRD PARTY ADMINISTRATIVE SERVICE RFP RECOMMENDATIONS – MR. CHRIS GIOVANNELLO, WTW and MS. JACLYN IGLESIAS, WTW**

Medicare Plan Option

Mr. Giovannello stated that in November the Proposal Review Committee (PRC) voted on the recommendations related to the Medicare plan options. The PRC determined that both Highmark Delaware and Aetna were qualified to administer both a Special Medicifill Medicare Supplement plan and a Group Medicare Advantage (Group MA) product to the Medicare pensioner population. The scoring of the two vendors ultimately determined that Highmark Delaware’s Medicare Advantage product scored higher than Aetna’s offering. The PRC

recommended that the State Employee Benefits Committee (SEBC) should reach a decision not later than March 31, 2022, in order to provide sufficient time for implementation of the plan option before the current Special Medicfill Medicare Supplement plan contract terminates on December 31, 2022.

Discussion was had regarding the options that have been proposed compared to what is currently being administered today, including review of the key components of group MA plans, the federal subsidies available to the GHIP under each option and considerations for including Part D drug coverage in a group MA offering.

Mr. Giovannello commented that compared to the current Medicfill plan there would not be any plan design changes if the State moved to a Group MA plan and the provider network would not change from a passive PPO network.

Mr. Taschner inquired which line item on the reported invoices would be eliminated if the Group Medicare Advantage with Prescription plan was selected. Mr. Giovannello responded all rebate payments that are related to the EGWP program, as well as EGWP related revenues (direct subsidy, coverage gap discount payment and federal reinsurance) would discontinue and any items that are related to the active/pre65 population would remain.

Mr. Giovannello summarized the key decision points for the SEBC: maintain Medicfill plan or move to Group MA product, effective 1/1/23 (or later); select Aetna or Highmark Delaware as the plan administrator; and include or exclude Part D drug coverage as part of the Group MA product.

Mr. Taschner expressed concern that moving to a Group MA product will reduce the revenue to the GHIP, considerably reduce the amount that the State must contribute to the GHIP, and the retiree population may have difficulty switching and understanding a transition to a Group MA offering. He asked Director Cade if there is a way to hold the actives/pre65 retirees harmless in order to make sure the move to a Group MA program does not result directly in a net increase to that group.

Director Cade commented that he shares Mr. Taschner's concerns that communication must be strategically implemented for the retiree population if the decision is to move forward with a Group MA product. However, there are not material changes to the plan. He commented that the vendors included transition credits in their proposals that could be used to cover the cost of communication and education materials and inquired what the dollar amount is that Highmark and Aetna offered as a transition credit. Ms. Rentz commented that she will follow up directly with committee members due to the proprietary nature of that information.

Mr. Giovannello concluded this portion of the presentation with a recap of the joint Subcommittees recommendation regarding a Medicare plan: Effective January 1, 2023, move to a Group MA plan, award administration of the plan to Highmark, and maintain existing self-funded EGWP coverage.

#### Active/Non-Medicare Plan Considerations

Ms. Iglesias explained that for the active/non-Medicare plan considerations for FY23, Subcommittee members discussed the following programs and formed recommendations for discussion during last week's meeting and is ultimately asking for the SEBC to take a vote based off Subcommittee member recommendations. These programs include the care management program option for each medical vendor, the PCP election/referral requirement of the Aetna HMO plan, and other FY23 opportunities for consideration.

Regarding the care management programs, Aetna has proposed two care management options for the State Group Health plan. Aetna's first program is called, "One Advisor", which targets more people, engages with them earlier, and uses more advanced technology. The second program is called, "One Flex", which targets fewer people, uses less advanced technology, however, is lower cost than "One Advisor". Both programs are new to the State Group Health plan, and both offer performance guarantees. Financially, the estimated cost savings for FY23

admin cost for the “One Advisor” would \$0.6M and “One Flex” the estimated cost savings for FY23 admin cost is \$1.7M. The combined Subcommittees met with Aetna in January to understand the key differences between the programs - focusing on the descriptions of each program, fees, performance guarantees, and outcomes achieved from case studies. Based on the deliberation among Subcommittee members, they ultimately agreed that the Aetna “One Advisor” program would be the best option for the State Group Health plan. They saw value in that the program would be able to identify more plan participants and engage with participants earlier, which would lead to a better member experience and improved health outcomes.

Highmark also proposed two care management options for the State Group Health plan. Highmark’s first program is called, “Well360 Clarity”, and is a new program that targets more people, is delivered in conjunction with a care management partner and offers more steerage of plan participants to high quality providers. The second option proposed is what the State Group Health plan has today and is called the “CCMU” (Custom Care Management Unit) program, which targets fewer people and includes clinical oversight provided by a different team of WTW resources on behalf of all mutual customers served by the CCMU. Financially, the estimated savings on FY23 admin fees for the “Well360 Clarity” would be \$0.6M, whereas the CCMU would increase estimated FY23 admin fees by \$0.1M. Both programs offer performance guarantees related to program outcomes. Highmark met with Subcommittee members in January to demonstrate the differences between the proposed programs and illustrate member scenarios under each option. After deliberation, the Combined Subcommittees agreed that the “CCMU” program would be better suited to continue supporting the State Group Health plan participants for FY23, with a willingness to consider reevaluating this decision throughout the subsequent years of the State’s contract with Highmark. Subcommittee members were concerned about adopting a program for which Highmark is using a new care management provider to deliver services to members and the lack of transparency into Highmark’s broader relationship with its care management provider, despite multiple inquiries requesting further details.

Pivoting to the next outstanding decision related to the Aetna HMO plan, today the State of Delaware’s Aetna HMO plan requires members to select a PCP upon enrollment and requires referrals for members seeking specialty care. In addition to maintaining the current HMO as it is administered today, Aetna’s proposal also included an option for the State to waive the current requirements for participants to select a primary care physician and obtain referrals. The Subcommittees discussed the possible implications of removing this requirement on plan costs and on GHIP revenue through enrollment migration from the PPO to the HMO plan (i.e., lost contribution of revenue for similar plan design, plus the potential impact on Highmark’s performance guarantees and other elements of Highmark’s financial proposal). Ultimately, Subcommittee members agreed that maintaining the requirement for the PCP selection and referrals is preferable to waiving this requirement.

Finally, Subcommittee members reviewed other FY23 opportunities that had previously been discussed at the Subcommittee level, but because no vote was taken at the December SEBC meeting, there was an opportunity to revisit the recommended options for consideration of whether these should be reintroduced at the SEBC level for evaluation and a potential vote. At last Thursday’s Subcommittee meeting, there was a discussion about how several updates to some FY23 opportunities had taken place since December and did not make them feasible for a vote in February or March in time to apply as savings against the FY23 deficit. These updates included discussion on foregoing any changes to telemedicine copays in FY23 with agreement to monitor ongoing utilization for the possibility of revisiting changes in the future, and discussion of the CVS Transform Diabetes Care program being considered alongside of other diabetes programs through the medical RFP, which will be discussed at the March Subcommittee meeting.

The CVS Drugs Savings Review program was also discussed on Thursday to gauge interest from Subcommittee members’ in maintaining the earlier recommendation to the SEBC to consider this program for FY23. The goals and key elements of the program were reviewed, which centers around identifying opportunities for improved prescribing practices and improved prescription drug utilization based on evidence-based medicine guidelines. This program involves outreach from CVS to prescribing physicians on behalf of specific members enrolled in the

State Group Health plan, with recommendations to those physicians on other opportunities to improve patient safety or help members save money on their prescriptions to potentially make changes for the betterment of the patient in their prescribing regimen. Providers would retain complete discretion over making any changes to their patients' prescriptions, so if a physician decides against making any changes to a member's prescription, then CVS will honor that physician's clinical opinion. This program has minimal member impact, which is only felt if the prescriber decided to change the patient's prescription drug regimen, underscoring the importance of provider engagement in driving the Return on Investment (ROI) and clinical impact of this particular program. It has a 3:1 minimum ROI guarantee (annual net saving range after member cost sharing \$1M-\$2.8). Discussion with the Subcommittee members about whether this program was truly voluntary for provider and recalled requirements to change prescriptions with the earlier PBM transition from Express Scripts to CVS. Ultimately, clarification was provided about the differences between those earlier situations where members may have had to change their prescriptions due to formulary differences and this program which would truly be voluntary for providers to determine whether a prescription would be changed. Further discussion also took place about the State of Delaware's ability to turn this program "On" or "Off" throughout the duration of the CVS contract if member experience wasn't meeting expectations. With this information provided, Subcommittee members remained in support of the SEBC considering the Drug Savings Review Program for FY23, with the additional caveat that monitoring should take place to ensure that the member experience, the provider community's engagement, and the program's first year results are all meeting expectations so that future years of the program could be reevaluated if those expectations are not met.

## **FINANCIALS – MR. CHRIS GIOVANNELLO, WTW**

### January Fund Report

The January Fund Report was reviewed. Mr. Giovannello clarified for Mr. Taschner the EGWP revenue items that would no longer be provided if the EGWP plan were to be removed. Overall, for the month of January, revenues came in close to what was expected. January claims ran favorable to budget, \$80.5M paid vs \$86.3M expected (\$5.8M surplus). The January surplus was in part driven by the transition of the EGWP plan from Express Scripts to CVS Health effective 1/1/22, which led to lighter than expected pharmacy invoices during the month. Overall, year to date budget through January is a \$35.1M surplus in claims. All in January fund experience generated net income of \$2.9M and ending fund equity balance is \$167.1M (variance to budget is \$31.4M).

### FY22 Q2 Financial Report

The quarterly financial report based on claims through December was reviewed; the report analyzes claims through the first six months of the plan year relative to the first six months of the prior fiscal year, and relative to budget. Gross claims for FY22 are trending higher when compared to FY21 (increased 3.7%). The total program cost is roughly flat (increased 0.5%), driven by overall favorable claims experience for the State of Delaware fund as well as increased pharmacy rebates. Per employee and per member per year program cost is down 0.2% and up 0.6% respectively. The FY22 actual experience relative to budget saw a decrease of 8.8% on total program cost and 8.6% on total per employee per year, and this was based on the favorable claims experience through December, as well as timing differences in the Fund and budget amounts relative to the vendor reports used in the quarterly financial report.

Mr. Giovannello pointed out that the loss ratios for Medicare retirees is 78%, for actives is 100%, and non-Medicare retirees is 134%. No concerns based on these ratios as it is typical to see pre-Medicare retirees generate more claims, and the budget rates for Medicare retirees are set higher than the cost of the program, as has been discussed previously with the SEBC.

Based on IBM Watson's quarterly dashboards, there was nothing unusual in the utilization data looking at the most recent 12 months ending December 2021 compared to the prior 12-month period. There are a few items that Mr. Giovannello did mention such as changes in well care and preventative visits (decreased 8.6% for well child and increase of 11.4% for preventative adult visits). Increased screening rates for colon cancer, breast

cancer, cervical cancer, and cholesterol. The State Group Health plan additionally saw an increase in the number of inpatient admissions and an increase in the severity of those admissions, which WTW is continuing to monitor. Pharmacy claims cost increased 7%, and utilization of all prescriptions increased 1.4%. Specialty medications make up 49% of pharmacy spend and saw a 0.9% increase in utilization.

Secretary Magarik queried, when a member is inpatient and utilizes medications dispensed by the hospital, whether that cost is incurred on the medical plan or on the pharmaceutical plan. Mr. Mateja confirmed that it is incurred on the medical plan.

#### FY23 GHIP Projections

The projections for FY23 have been updated to include \$24 million in COVID-19 reimbursement funds. The payment for these claims is expected to be received during FY23 based on claims that were attributable to calendar year 2021. No additional COVID-19 funding relief is reflected in the projections as funding relief would offset COVID-19 related expenses.

Mr. Giovannello made note that the GHIP long-term projections have been updated to reflect all legislation signed into law and initiatives voted on by the SEBC as of February 24<sup>th</sup>, 2022. GHIP long term health care cost projections for FY23 are reflected with the following legislative impact factored in: Senate Bill 25, which pertains to chiropractor reimbursement not less than Medicare, went into effect January 1, 2022, and has been included in the projections for FY22 with an added cost of \$0.5 million in FY22 and FY23. Other legislation either anticipated to be passed or passed with an effective date on or before the end of FY23 are not currently built into the projections. Most notably, Senate Bill 120, the primary care reimbursement bill, which Highmark estimates a fiscal year impact of \$4.6M - \$29.9M per year for the Highmark population only, is not built into the projections. Aetna has not provided a similar estimate. While these costs are not built into the projections, they should be considered when discussing potential rate action for FY23.

FY22 projection of \$30.2 million surplus will be fully depleted during the subsequent plan year, resulting in a \$62.7 million deficit projected for FY23. The one-time rate action needed to solve for the \$62.7 million deficit in one year would be 8.67%. Smoothing the rate increase over three years to target \$0 deficit by the end of FY25 requires an 8.98% annual rate increase in FY23-FY25. Discussion was had on the member impact scenarios tied to each rate action that illustrated the monthly and annual increases by medical plan and coverage tier.

Mr. Taschner asked about the 8.67% rate increase, per Mr. Taschner's analysis and calculation he found that 7.41% rate increase would be the rate action needed to solve for this deficit if the rate changed proportionally with the change in deficit; Mr. Taschner questioned how Mr. Giovannello reached the 8.67% rate increase. Mr. Giovannello responded that the calculation comes down to the subsidization that was previously discussed. The 8.67% rate increase is now based on moving to a Group Medicare Advantage plan and for the first six months of FY23, the State will have the increased subsidization of the current Medicfill rates on the pre-65 and active population rates. Then on January 1, 2023, the subsidization will decrease as the Medicfill rate for medical will convert to the fully insured rate. Historically WTW has not factored in the move to a Group Medicare Advantage Plan and the lost subsidy when presenting the rate increases needed to solve for the projected deficits. Additionally, in the scenarios where Medicfill would be maintained, the Medicfill subsidization would carry forward for the first six months of the fiscal year. Mr. Taschner asked if there is any way that a smoother transition of rates could happen as 7.41% is more favorable than 8.67% from a plan member increase standpoint. Director Cade responded that if the SEBC were just looking at FY23, then they might consider this, but the fact that they are considering the impact of this rate action on future deficits and rate actions makes the decision more complex. Further, there has not been a rate increase since FY17. That's theoretically the concern we run into that whenever we talk about a rate increase, we try to balance that with the impact it will have on employees, in real dollars. Even when we're just looking at this year, we're recommending a significant pay increase for State employees which should absorb a portion of the rate increase. Mr. Taschner acknowledged that he is not opposed to a rate increase as the State of Delaware has had a favorable five-year period and hasn't

raised the rates since FY17. Mr. Taschner indicated he was not convinced that the 8.67% rate increase is what is needed at this point.

Secretary DeMatteis commented that the overall cost of the rate increase to employees, even considering the Governor's proposed salary increases, ranges between \$26 and \$250 annually. Recognizing that rates are increasing along with inflation driving up all other costs as well, she suggested that the Committee think about the increase in terms of dollar amounts, not just percentages. Mr. Taschner reiterated his understanding that an increase is needed, but again not convinced that an 8.67% rate increase is the right amount. He referenced earlier discussions of potential savings with the SEBC in December 2021 related to the site of steerage in the range of \$30-\$33M. Mr. Taschner expressed concerns that if this rate increase is to take place, it will take the pressure off the potential to reduce overall plan cost in other potential areas of medical and pharmaceutical spend that would be beneficial to plan participants, the State and Delaware taxpayers. Ultimately, he wanted to focus on solutions that lower the overall cost of the plan rather than jumping to increasing rates by 8.67%.

Secretary Magarik commented that part of the challenge is that many of the other actions the SEBC could take to drive costs down (which they have discussed as a Committee) are many years into the future such as reference-based pricing. While several other measures have been taken, they seem to be largely incremental and don't dramatically affect the trend. Other remaining actions the Committee could take are not things that could be undertaken quickly enough to realize FY23 savings that would warrant putting off a rate increase. She acknowledged that she agreed with Mr. Taschner, that we must continue to put pressure on the vendors and look for ways to reduce overall plan cost because the cost of healthcare inflation is unyielding, but the SEBC also needed to implement a rate increase to solve for the FY23 deficit in the short term.

Director Cade added that the SEBC and its Subcommittees have looked at other cost reduction options at the end of last year, however no other options were enticing either because the effort to make the change wouldn't produce meaningful savings or because there were concerns about disruption to members. He agreed with Secretary Magarik that the conversation about medical cost reductions is one that must continue in the future and those solutions either will not yield immediate savings that would address the deficit in FY23 or FY24 or will produce near-term savings that are negligible. Mr. Taschner responded that he wants the SEBC to start making progress towards evaluating those future opportunities for longer-term savings and noted that even the site of care changes discussed in December could achieve some significant cost savings now if State Group Health Plan could drive the members to a different provider. Mr. Taschner added that, for example, while he understands that not every visit to an emergency room may be appropriate to redirect to an urgent care center, based on data presented at the December Subcommittee meeting, the GHIP could have saved \$13.2M in FY21 if emergency room visits were redirected to urgent care, and that savings likely carries through year after year. He questioned what the SEBC needed to do to drive those emergency room visits to urgent care (i.e., those that can be moved into the urgent care setting) and for those non-emergent conditions that do get treated at an emergency care setting, whether there is a significant increase in cost compared to an urgent care setting and why is that. Mr. Taschner ultimately wanted to ensure that the SEBC doesn't lose sight of site-of-care steerage opportunities like that example and ensuring that what whatever the State is paying is the appropriate premium and driving cost down to the extent we can.

As there were no further comments on this topic, the presentation turned to the member impact scenarios associated with an 8.67% increase effective 7/1/2022. This reflects an employee contribution increase ranging between \$2.41 - \$23.66 per employee per month (\$28.92 - \$283.92 per year) and State subsidy increases of \$57.88 - \$156.14 per employee per month (\$694.56 - \$1,873.68 per year) effective 7/1/2022. The State picks up a much larger piece of this increase, so anytime that the SEBC opts to forego a potential premium increase, it more significantly reduces the revenue input by the State. To Mr. Taschner's point, regarding the dollar difference in the required premium increase after a move to Group MA vs. maintaining Medicfill, the value of the additional Medicfill subsidy is worth about 2% of the overall rate increase, which on the high side is worth about

\$65 for an employee with Family coverage in the Comprehensive PPO plan, which is baked into the \$283.92 increase.

Also discussed were the current premium rates for Medicfill that would remain in effect through the first six months of FY23, along with the premium rates under the Subcommittees' recommended plan option (Highmark group Medicare Advantage, medical only, retaining the CVS EGWP). With maintaining the EGWP Rx benefit under CVS, the premium rate for drug coverage will maintain some of the Medicfill subsidization that we're seeing happen today since the Rx rate is also higher than the cost of the plan. There would be no change to the structure in terms of how retirees contribute toward that premium. The presentation walked through an example of a pensioner that has retired after July 1, 2012. All Medicfill premium rates would reduce under the new rate structure.

*Chief Justice Seitz left the meeting.*

#### **OTHER BUSINESS**

No new business was presented.

#### **PUBLIC COMMENT**

A retiree expressed concern about the GHIP's recent transition to the new PBM. The retiree's specialty medication has been denied for medical necessity when it was previously covered under ESI's formulary. Insurance Commissioner Navarro commented that there is an appeal process through the State that the retiree could consider, and this isn't a challenge with the insurance company per se; rather, it has to do with the drug manufacturer may not be tied to SilverScript. The SBO could assist the retiree with obtaining information about the State's appeal process.

#### **FY23 HEALTH PLAN PREMIUM RECOMMENDATIONS\***

##### **Medicare Plan Option – DIRECTOR CADE, CO-CHAIR**

Subcommittees recommend moving to Group Medicare Advantage plan (medical only), effective 1/1/2023, administered by Highmark, and to continue offering drug coverage through CVS EGWP.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Subcommittees' recommendation for moving to a Group Medicare Advantage plan (medical only), effective 1/1/2023, administered by Highmark, and to continue offering drug coverage through CVS EGWP.

##### **MOTION ADOPTED UNANIMOUSLY**

Ashley Tucker is voting on behalf of Chief Justice Seitz.

Keith Warren is voting on behalf of The Lieutenant Governor.

##### **Care Management program decisions – DIRECTOR CADE, CO-CHAIR**

HMO and CDH Gold plans: Subcommittees recommend Aetna One Advisor.

A MOTION was made by Secretary Magarik and seconded by Secretary DeMatteis to accept the Subcommittees' recommendation to adopt Aetna One Advisor ("Option 1") for the HMO and CDH Gold plans.

##### **MOTION ADOPTED UNANIMOUSLY**

Ashley Tucker is voting on behalf of Chief Justice Seitz.

Keith Warren is voting on behalf of The Lieutenant Governor.

Comprehensive PPO and First State Basic plans: Subcommittees recommend continuing with the Highmark CCMU.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Subcommittees' recommendation to continue with the Highmark CCMU for the Comprehensive PPO and First State Basic plans, and in addition to this MOTION Highmark should provide additional transparency into its relationship with its care management partner for the Well360 Clarity care management program, which is not being recommended by the Subcommittees at this time but would potentially be considered in future years.

MOTION ADOPTED UNANIMOUSLY

Ashley Tucker is voting on behalf of Chief Justice Seitz.

Keith Warren is voting on behalf of The Lieutenant Governor.

**Aetna HMO – DIRECTOR CADE, CO-CHAIR**

Subcommittees recommend retaining the requirement for PCP selection and referrals.

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Subcommittees' recommendation for retaining the HMO plan's requirement for PCP selection and referrals.

MOTION ADOPTED UNANIMOUSLY

Ashley Tucker is voting on behalf of Chief Justice Seitz.

Keith Warren is voting on behalf of The Lieutenant Governor.

**CVS Drug Savings Review Program – DIRECTOR CADE, CO-CHAIR**

Subcommittees remain in support of the SEBC considering this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23.

A MOTION was made by Secretary Magarik and seconded by Secretary DeMatteis to accept the Subcommittees' recommendation for adopting this program for FY23, but with continued monitoring of the member experience, physician engagement and program results throughout the first year of the program for reconsideration of continuing the program past FY23.

MOTION ADOPTED UNANIMOUSLY

Ashley Tucker is voting on behalf of Chief Justice Seitz.

Keith Warren is voting on behalf of The Lieutenant Governor.

**FY23 Rate Action – DIRECTOR CADE, CO-CHAIR**

Financial Subcommittee recommends an 8.67% rate increase effective 7/1/2022 to solve for the projected FY23 deficit of \$62.7M

A MOTION was made by Secretary DeMatteis and seconded by Secretary Magarik to accept the Financial Subcommittee's recommendation of an 8.67% rate increase effective 7/1/2022 to solve for the projected FY23 deficit of \$62.7M.

MOTION FOR DISCUSSION

Mr. Taschner stated that for the reasons he discussed earlier, he will be voting "No" because he is not convinced that an 8.67% increase is necessary though he does support some level of increase. He also voiced concerns about this being characterized as a "recommendation" from the Subcommittee since as he understood it, there was no vote taken by the Subcommittee but rather a discussion on this topic in which some Subcommittee members acknowledged the necessity of a rate increase, but others did not voice an opinion. He did not believe that there was an affirmative recommendation from the majority of Subcommittee members. Ms. Rentz responded that she has had additional discussions with the majority of Subcommittee members and a number of SEBC members since Thursday's meetings and addressed questions and concerns coming out of those

discussions. Additionally, as the SEBC is aware, the Subcommittees are not voting bodies and only put forth recommendations.

Controller General Jones acknowledged that Mr. Taschner's statement is right, that a large portion of the rate increase is still funded by the General Fund, when we talk about the State's share. Regarding the Governor's Recommended Budget including a one-time amount of \$82.8M for the Group Health Insurance Plan, Controller General Jones inquired about the intent of how that funding would be used for the Plan. Director Cade responded that the one-time funding in the Governor's Recommended Budget would not be needed as that was a "worst case scenario" if nothing was solved by the SEBC. The concern, if the SEBC chose against implementing a rate increase in FY23 and tapped into the one-time funding, there would be a larger rate increase required to cover the deficit in FY24. Controller General Jones asked for confirmation that there is nothing in the Governor's Recommended Budget to cover the rate increase, to which Director Cade responded no, this is something that they will need to reconcile during mark-up.

Secretary Magarik indicated that we must be good stewards of taxpayers' dollars, however these scenarios continue to get worse if we don't take a rate action this year. Respectfully, if action is not taken to increase the rates by 8.67% for FY23 and take other actions to solve for savings longer term, the deficit will be dramatically worse in the future. Moving people away from emergency departments is not a quick fix and there are other actions that the SEBC can take. Secretary DeMatteis supports Secretary Magarik's comments and indicated that the deficit has also been mitigated by an influx of federal dollars associated with COVID treatment costs and therefore believes this is a responsible rate increase. Insurance Commissioner Navarro added that no one wants to implement a rate increase, but this action is the prudent thing to do at this point. Mr. Taschner commented that he is not against a rate increase, but not convinced the 8.67% is what is needed. Director Cade responded that at this point the State Group Health plan must act in order to be ready for Open Enrollment but agreed with Mr. Taschner that the rate increase has decreased consistently over the last several financial updates. Secretary DeMatteis added that the recommended salary increase also mitigates the impact of the rate increase, understanding that all costs are going up right now. Treasurer Davis expressed concern that any site of steerage changes must be made carefully to avoid any negative effects on a member's medical needs.

**MOTION NOT ADOPTED UNANIMOUSLY – ALL IN FAVOR EXCEPT FOR MR. TASCHNER**

Ashley Tucker is voting on behalf of Chief Justice Seitz.

Keith Warren is voting on behalf of The Lieutenant Governor.

#### **ADJOURNMENT**

A MOTION was made by Mr. Taschner and seconded by Secretary Magarik to adjourn the Public Session at 4:17 p.m.

**MOTION ADOPTED UNANIMOUSLY**

Respectfully submitted,

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Carole Mick, Administrative Specialist III, Statewide Benefits Office, Department of Human Resources  
Recorder, State Employee Benefits Committee, and Subcommittees